

EXHIBIT K



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
 [This form has been approved by the New York State Department of Health]

Patient Name Lauren Andersen	Date of Birth [REDACTED]	Social Security Number [REDACTED]
Patient Address [REDACTED]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information: (see annexed list)															
8. Name and address of person(s) or category of person to whom this information will be sent: Lauren Andersen, PO Box 500, Cold Spring Harbor NY 11724															
9(a). Specific information to be released: <table border="0" style="width: 100%;"> <tr> <td style="width: 15px;"><input checked="" type="checkbox"/></td> <td>Medical Record from (insert date) _____ to (insert date) _____</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Other: <u>legal documents</u> _____ _____</td> </tr> <tr> <td colspan="2" style="text-align: right;">Include: (Indicate by Initialing)</td> </tr> <tr> <td colspan="2" style="text-align: right;"><input checked="" type="checkbox"/> Alcohol/Drug Treatment</td> </tr> <tr> <td colspan="2" style="text-align: right;"><input checked="" type="checkbox"/> Mental Health Information</td> </tr> <tr> <td colspan="2" style="text-align: right;"><input type="checkbox"/> HIV-Related Information</td> </tr> </table>		<input checked="" type="checkbox"/>	Medical Record from (insert date) _____ to (insert date) _____	<input checked="" type="checkbox"/>	Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.	<input checked="" type="checkbox"/>	Other: <u>legal documents</u> _____ _____	Include: (Indicate by Initialing)		<input checked="" type="checkbox"/> Alcohol/Drug Treatment		<input checked="" type="checkbox"/> Mental Health Information		<input type="checkbox"/> HIV-Related Information	
<input checked="" type="checkbox"/>	Medical Record from (insert date) _____ to (insert date) _____														
<input checked="" type="checkbox"/>	Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.														
<input checked="" type="checkbox"/>	Other: <u>legal documents</u> _____ _____														
Include: (Indicate by Initialing)															
<input checked="" type="checkbox"/> Alcohol/Drug Treatment															
<input checked="" type="checkbox"/> Mental Health Information															
<input type="checkbox"/> HIV-Related Information															
Authorization to Discuss Health Information <p>(b) <input type="checkbox"/> By initialing here _____ I authorize _____ Initials _____ Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here: _____ (Attorney/Firm Name or Governmental Agency Name)</p>															
10. Reason for release of information: <input checked="" type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire: Oct. 31, 2022														
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:														

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law.

Date: **January 22, 2022**

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

defendant name and address (from line 7, previous page)

British Airways PLC ("BA"), 2 Park Avenue, Suite 1100, New York, New York 10016

Anthony Battista Esq.) c/o Condon & Forsyth LLP, 7 Times Square, New York, NY 10036
Condon & Forsyth LLP, ditto

the Port Authority of New York & New Jersey ("PANYNJ"), OIG, 5 Marine View Plaza, Hoboken NJ 07030.

Mr. Huntley Lawrence, Acting Chief Operating Officer & Director of Aviation, ditto

Ms. Karen T. Connelly, Assistant Director, Office of Inspector General, Police Integrity Division (suite 316)

Michelle Serrano, CCIU/OIG, ditto

PAPD officer Sgt. Danielle Liantonio - c/o PAPD station, 269 S Service Rd, Queens, NY 11430

P.O. Michael Corwin #2524 - ditto

T.C. Daniel Carbonaro - ditto

Northwell Health ("Northwell"), c/o their attorneys HPMB. 99 Park Ave, New York NY 10016.

Mr. Michael J. Dowling, ditto

Dr. Mark Russ, ditto

Dr. John Kane, ditto

Dr. Melissa Dudas, ditto

Ms. Renee Lifshitz, ditto

Dr. Mitchell Shuwall, ditto

Dr. Bruce Levy, ditto

Ms. Marybeth McManus, ditto

Northwell Laboratories, 972 Brush Hollow Rd 5th Fl., Westbury, NY 11590-1740

UnitedHealthcare Community Plan of New York (UHCPNY) c/o Robinson & Cole, 666 Third Ave., 20th fl, NY, NY 10017.

Mr. Matthew Mazzola Esq., ditto

Robinson & Cole, ditto

UnitedHealth Group served at UHG's headquarters, 9900 Bren Road East, Minnetonka, MN 55343.

Madeline Harlan also at UHG's HQ in Minnesota

Former US Congressman Peter King, Esq. (#1232743), 1003 Park Boulevard, Massapequa Park, NY 11762-2741

Michael Schillinger, Esq. (#5501911) is at 142 Freeman Ave, Islip, NY 11751

The City of New York ("NYC") is at 100 Church St, New York, NY 10007.

EMS technician only known as "Frank 50" (shield #5613), 9 Metrotech center, brooklyn

Ms. Judith A. Pascale, Suffolk County Clerk, is at 310 Center Drive, Riverhead, NY 11901.

Mr. Jonathan B. Bruno, Esq. is c/o Rivkin Radler LLP, 477 Madison Ave, Suite 410, New York, NY 10022.

Kaufman Borgheest & Ryan LLP ("KBR"), Northwell's former defense firm, 120 Broadway, 14th floor, New York, NY 10271.

Heidell Pittoni Murphy & Bach LLP ("HPMB"), Northwell's current defense law firm. 99 Park Ave, New York NY 10016.

Mr. Daniel S. Ratner Esq. is the Managing Partner, ditto

Mr. Daniel G. May, Esq. is a Partner, ditto

Graham T. Musynske Esq., 1050 Franklin Ave, unit 408, Garden City, NY 11530

Rachel Bloom Esq., ditto at garden city office

David A. Rosen Esq. former Associate of HPMB, now at EmPRO Insurance, 1800 Northern Blvd, Roslyn, NY 11576.

Mr. Jeffrey Carucci, Division of E-Filing, Office of Court Administration ("OCA"), 25 Beaver St # 8, New York, NY 10004.

Mr. Justin Barry is his supervisor, Chief of Administration, ditto

Ms. Sherrill Spatz, Esq., is Inspector General, ditto

City Bar Association, 42 W 44th St, New York, NY 10036.

Mr. Bret Parker, Esq., Executive Director of the City Bar, ditto

Letitia James, New York State Attorney General ("NYSAG"), is c/o The Capitol, Albany, NY 12224-0341.

"Alex" (last name unknown), NYSAG's healthcare bureau in NYC, 28 Liberty St, New York, NY 10005